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COMMENTARY
Considerations on the road to involuntary confinement

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Mr. Martinez came from the Philippines to San Francisco. He came with other 70-year-old veterans, naturalized citizens who had been promised a monthly social security check for supporting the Allies in World War II. He left behind his family and most of his material goods, but he brought along his drug-resistant tuberculosis. From late at night until dawn, he worked with other Filipinos, cleaning and completing odd jobs around the casinos in Reno, Nevada. By the time his illness was diagnosed, a few years after he arrived in the United States, he could no longer support himself or send money home.

Because his tuberculosis was drug-resistant, he was placed on directly observed therapy (DOT). He came into the clinic or met with someone at his home or in the neighborhood who would watch him take his pills. He said he was not an educated man and had trouble remembering his weekend dose of medications. While he did not mind the directly observed therapy, he needed his extra income and would leave for Reno once or twice a week.

The clinic staff was sympathetic but resolved to hold Mr. Martinez to the rigors of directly observed therapy. They had sent their Filipino health worker to educate him; they had offered him sandwiches, bus tokens, and kind words. Treating him through the tuberculosis clinic in Reno was not an option since he worked irregularly and at different places. He was a public health threat. What was left except to confine him involuntarily in the hospital or the jail?

Tuberculosis is the classic disease for observing the interplay between individual rights and public health protection. Directly observed therapy, implemented by skilled health workers and enhanced with incentives and enablers, is the primary tool for successful treatment of tuberculosis,[1] but it does not always work. Lerner has examined the evolution of confinement in Seattle, Washington, as a means of controlling tuberculosis.[2] Now, as then, while involuntary confinement appears the ultimate tool for successful treatment of tuberculosis, closer examination suggests that less coercive measures may be more suitable.

In the United States, public health emphasis has seesawed between chemotherapy and behavioral therapy. When new drugs for treating tuberculosis became available in the 1950s, behavioral interventions were shunted aside, only to reemerge as a critical tool with the new round of epidemics in the late 1980s. The rise in the number of people with the disease and the development of multidrug resistance, due primarily to poor therapy adherence, motivated changes in tuberculosis programs. Behavioral interventions, in the form of directly observed therapy, have been the treatment of choice since adherence seized the

agenda in the prevention and treatment of tuberculosis. While most patients respond to orders for directly observed therapy, many states revamped old public health laws to enforce treatment. Involuntary confinement is seen as the ultimate tool in treatment. In a systematic evaluation of involuntary confinement in California, however, 3 questions arose: How effective is coercion as a control measure for tuberculosis? Is it applied equitably across counties? How frequently available and utilized are less coercive measures, including comprehensive psychiatric and addiction care?[3]

Is involuntary confinement effective? In the study by Oscherwitz et al., 84% of confined patients eventually completed therapy although most were not forced to remain confined to the end of treatment. While this is a high percentage of treatment completion in a difficult group of patients, Centers for Disease Control guidelines call for 90% completion rates.[4] Even using the "ultimate tool" for control, success is not guaranteed.

Is involuntary confinement being equitably applied? Patients in the California study who were identified as needing involuntary confinement were more often young, homeless, and unemployed, with drug and alcohol histories, as compared with patients who were more adherent to therapy for tuberculosis. The rates of tuberculosis patients needing confinement varied widely by county. Some tuberculosis control officers reported attempting to confine no one; others confined up to 8.9% of their cases in the study years examined. Counties varied widely in their access to suitable places to confine contagious patients, in their relationships with the sheriffs and judges needed to implement and maintain confinement orders, and in their philosophy about the use of involuntary confinement.

Are control officers considering less coercive measures? Evaluation and treatment of comorbid illnesses might actually interfere with the ability to accept therapy for tuberculosis. Where substance misuse or mental illness was identified in nonadherent patients, fewer than half were documented as having been referred for care of these illnesses prior to their planned involuntary confinement.

The larger question of protection of rights is raised for tuberculosis patients who also suffer from mental illness or substance misuse. Is it fair to use threats such as involuntary confinement if the patient's ability to understand the consequences is impaired? The bacilli of the mentally ill patient may be just as contagious as the mentally well patient's. Are the rights of the former being upheld if he or she does not comprehend the connection between behavior and punishment? This question is particularly important when one considers the availability of routine mental health assessments by trained professionals in tuberculosis control programs. Few have access to staff that are trained in mental health assessment, and almost none are able to offer professional interventions on site.

Most publicly available mental health care comes from the same public health departments that fund tuberculosis control. There may be long waits for assessments. Access to ongoing treatment may be available only for the most seriously impaired. Access to drug and alcohol treatment programs is more available, but in many counties court orders are required to put patients at the top of the treatment waiting lists.

Are there options better than confinement? Positive-value incentives have been used widely, though casually, in most control programs. Programs rely on noncash incentives such as meals, vouchers for food, transportation assistance, an occasional birthday card, or flowers from the staff gardens to engage and reward patients. Studies of protocol-guided use of cash and noncash incentives are showing rates greater than 80% in completion of appointments to the tuberculosis clinic and completion of therapy.[5-7] Small cash incentives bring screening and preventive therapy completions to rates equal to the best efforts of highly skilled tuberculosis control programs that use conventional methods.[8] While none of these studies has compared cash incentives to the threat of or use of involuntary confinement as a tool for implementing directly observed therapy, there is clearly potential for less overtly coercive means of completing treatment.

The use of cash incentives for health care engenders much debate among public health specialists. The slippery slope of getting into the business of "paying to get healthy" looms large in the minds of all who contemplate the prospects of cash distribution at the local tuberculosis clinic. Would people try to get tuberculosis so they could be paid to take medication? If we pay for tuberculosis care, will we have to start paying people to take their pills for sexually transmitted diseases and AIDS? Where individual health and public health concerns overlap, these dilemmas are real.

While there are difficult ethical and social issues in the use of incentives, perhaps we must accept that in matters of individual rights and public health there are no easy fixes. If a "tuberculosis stipend" offers our Filipino veteran an incentive to stay home and comply with his directly observed therapy, and furthermore keeps him out of the locked ward in the county jail, which would you prefer to consider as the option of last resort?

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